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Investigation of Childhood Trauma Experiences and Family Functions among University Students

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Abstract

This study aims to investigate the childhood trauma experiences and family functions among university students. Participants were 647 students from a Faculty of Education. Childhood Trauma Questionnaire, Family Assessment Device and a socio-demographic form were used. The results of this study indicated that females assess their family functions more healthy than males. Education of the mother is important in the assessment of the family functions. According to this, it can be suggest that studies about consciousness to society must be done about traumatic experiences and healthy parent attitudes.

Keywords: Childhood trauma, ckildhood abuse, traumatic experiences, family functions, university students

1. Introduction

Childhood trauma is increasingly recognized as an important public health problem. It affects emotional, social, and physical development negatively. It is also related to intrapersonal and interpersonal difficulties. Many studies about intrapersonal difficulties have demonstrated that childhood trauma is related to some physical and psychological disorders (depression, anxiety, suicide, posttraumatic stress disorder, etc.) (Plener, Singer, & Goldbeck, 2011; Ursoniu, Putnoky, Vlaicu, & Vladescu, 2009; Marx & Sloan, 2002; Meyerson, Longa, Miranda, & Marx, 2002; Scheier, Botvin, & Miller, 1999). More recently, researchers have also examined the interpersonal distress and difficulties have effects on childhood trauma. They have shown that people who experienced of childhood trauma had suffered from lower quality relationship, intimacy dysfunction, parenting attitudes, social adjustment difficulties, problems in attachment, and family conflict (Kim, Trickett, & Putnam, 2010; Meyerson et

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al., 2002; Davis, Petretic-Jackson, & Ting, 2001; Rumstein-McKean & Hunsley, 2001). These studies were conducted in treatment settings. Childhood trauma usually affects family functions. Fewer studies have examined the effects of childhood trauma on family functioning. Limited number of studies indicated that physically abused adolescent females perceived their family environments as more conflictual and less cohesive than females without physical abuse, and sexually abused females perceived their family environments as more conflictual and less cohesive than females without sexual abuse (Meyerson et al., 2002). But there are no studies investigating the relation between various dimensions of childhood trauma and family functioning in community settings.

In this respect, the aim of this study was to examine the effects of physical, emotional and sexual childhood trauma experiences on perceived different family functions among university students. It was hypothesized that childhood traumatic experiences would be related to family functioning among university students.

2. Method

2.1. Subjects

This study is a survey research conducted among 802 students studying at Faculty of Education at Baskent University in Ankara. In this faculty, seven departments were selected. Convenient sampling was used since it was more practical and easy for the researchers to reach the sample. The study protocol was approved by Baskent University.

Of the total of 647 participants, 80.67 % of the sample (female=83.6%, male= 15.5%) participated in the study. The mean age of the sample was 21.4 ±1.8 with a range from 18 to 34 years.

2.2. Instruments

2.2.1. The Sociodemographic Form

This is a self-rating form prepared by the authors and it involves questions about sociodemographic status, academic year, department, subjective evaluation of academic performance, residence of the student, education level of the father and the mother, and subjective evaluation of the family income.

2.2.2. Family Assessment Device (FAD)

This was first developed by Epstein et al. (1983) and its validity and reliability studies for the Turkish population were run by Bulut (1990). It describes structural and organizational properties of the family group and the patterns of transactions among family members, which distinguishes healthy and unhealthy families. The model identifies six dimensions of family functioning: Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, and Behavior Control. The FAD has seven subscales: one General Functions scale, which assesses overall health and pathology of the family, and one subscale for each of the six dimensions. The FAD consists of 60 items rated with a 4-point Likert response format. In this study, Cronbach's alpha was 0.93.

2.2.3. Childhood Trauma Questionnaire (CTQ)

This scale was developed by Bernstein et al. (1994) and adapted to the Turkish population by Aslan and Alpaslan (2000). It consists of 40 items. This inventory assesses self-reported experiences of abuse and neglect before the age of 18 years. Items on the CTQ begin with the phrase "When I was growing up," and are rated on a 5-point Likert-type scale according to frequency with which experiences. A high score corresponds to high frequency of experiences of abuse and neglect. It has 3 subscales which are "Physical Abuse-PA" (19 items), "Emotional Abuse and Neglect-EAN" (16 items) and "Sexual Abuse-SA" (5 items). In this study, Cronbach's alpha was 0.86.

2.3. Procedures

Questionnaires were attached to the socio-demographic form randomly. Questionnaire forms were distributed to the participants by lecturers while they were in attendance of the required course. Students were assured that their responses would be confidential, and they were informed that they were not obliged to complete the questionnaire. The respondents were instructed to place the completed questionnaire forms in the same envelope before the forms were retrieved.

2.4. Analysis

The relationships between the scores of CTQ subscales and the scores of FAD subscales were investigated computing the Pearson correlation analysis. FAD scores were assessed as healthy and unhealthy family functions. The differences between means of the childhood trauma subscales and healthy/unhealthy family functions were computed through t-test. Next, multivariate logistic regression analysis was performed seven times. Healthy and unhealthy family functions were taken as the dependent variable in this analysis. On the other hand, gender and subscales of the CTQ were taken as independent variables. SPSS 16.0 statistical software program was used for the statistical analyses.

3. Results

Bivariate analysis was performed to examine the relationship between scores of subscales of FAD and CTQ. As a result, positively moderate ($r=.303$-$.420$; $p<.01$) and low correlation coefficient ($r=.127$-$.297$; $p<.01$) was found between subscales of FAD and CTQ.

Independent sample t-test was conducted to determine the difference between the means of the subscales of CTQ and healthy and unhealthy family functions scores. Results indicated that students with unhealthy problem solving have more PA, EAN and SA scores than students with healthy problem solving ($t=5.796$, $p<0.000$; $t=6.573$, $p<0.000$; $t=3.151$, $p<0.002$; respectively). Furthermore, results showed that unhealthy communication scores have significantly higher level of PA, EAN and SA scores than healthy communication scores ($t=6.059$, $p<0.000$; $t=7.311$, $p<0.000$; $t=2.710$, $p<0.007$; respectively). Also there were statistically significant differences between the means of healthy/unhealthy roles in the subscales of the CTQ ($t=7.027$, $p<0.000$; $t=7.683$, $p<0.000$; $t=2.715$, $p<0.007$; respectively). The higher scores on the subscales of CTQ were obtained for unhealthy affective

responsiveness (t=5.889, p<0.000; t=6.556, p<0.000; t=3.409, p<0.001; respectively). In addition, students with unhealthy affective involvement possess more PA, EAN and SA scores than students with healthy affective involvement (t=5.317, p<0.000; t=6.321, p<0.000; t=3.861, p<0.000; respectively). Furthermore, results showed that unhealthy behavior control scores have significantly higher level of PA, EAN and SA scores than healthy behavior control scores (t=5.022, p<0.000; t=6.103, p<0.000; t=3.242, p<0.001; respectively). Also there were statistically significant differences between means of healthy/unhealthy general Functions in the subscales of the CTQ (t=6.871, p<0.000; t=7.967, p<0.000; t=3.614, p<0.000; respectively).

The statistically significant relationships were additionally tested by conducting seven separate multivariate logistic regressions. Table 1 displays the predictor variables, determining the family functioning. According to this logistic regression, only one significant relationship emerged. Being female (Odds Ratio=1.143-2.982) is a determinant of unhealthy roles. Significant relationships between subscales of CTQ and family functioning were found. PA was related with problem solving, roles, affective responsiveness, and general functions. A high level of PA was the predictor of unhealthy problem solving, roles, affective responsiveness, and general functions. According to the regression model, EAN score was related with other six subscales of FAD, but not related with problem solving. That is, as level of EAN increased, also communication, roles, affective responsiveness, affective involvement, behavior control, and general functions increased.

4. Discussion

This study aimed to investigate the impact of childhood traumas which are PA, EAN, and SA on family functioning. The results of it may have important implications in identifying the childhood traumatic experiences and healthy and unhealthy family functions among university students.

According to the results, there was a low correlation between problem solving, affective involvement and behavior control subscales of FAD and PA and EAN subscales of CTQ. Childhood traumas of PA and EAN did not affect the problem solving, affective involvement and behavior control in the family. In Turkish culture, the approach appears as such although like that although parents show PA or EAN to their children, they think that he or she is my father or mother but this situation does not affect negatively their parent-children relations. Davidson & Mellor (2001) also reached similar findings**.**

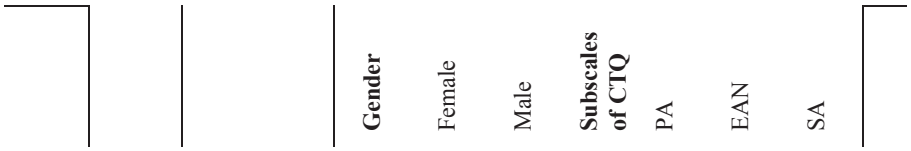
Also, there was a low correlation between all of the subscales of FAD and childhood sexual abuse. This result was not surprising. One explanation of this may be the responses of the students on items of sexual abuse (it consists of 5 items). The most frequently response is “never true” reaction. It ranges from 91.2-96.4%. This high ratio may cause low correlation. As in any systems model, an event that impacts any member of the family influences every other family member as well as all other family relationships and also the family as a whole (Kiser & Black, 2005). Therefore, effects of childhood trauma were investigated. In this study, important differences were found between

childhood trauma experiences in healthy and unhealthy family functioning, which are problem solving, communication, roles, affective responsiveness, affective involvement, behavior control, and general functions among university students. Students with higher physical, emotional, and sexual abuse experiences in childhood

Table 1. Predictors of subscales of FAD determined by multivariate analysis

Problem Solving		Communication		Roles		Affective Responsiveness		Affective Involvement		Behavior Control		General Functions	
Exp (B)	95% CI for Lower-Upper	Exp (B)	95% CI for Lower-Upper	Exp (B)	95% CI for Lower-Upper	Exp (B)	95% CI for Lower-Upper	Exp (B)	95% CI for Lower-Upper	Exp (B)	95% CI for Lower-Upper	Exp (B)	95% CI for Lower-Upper
.758	.471-1.220	1.135	.705-1.825	1.826	1.143-2.982*	1.457	.909-2.337	1.304	.816-2.083	1.195	.747-1.910	1.023	.625-1.674
1		1		1		1		1		1		1	
1.033	1.000-1.067*	1.029	.997-1.061	1.054	1.018-1.091*	1.035	1.002-1.069*	1.028	.996-1.062	1.022	.991-1.053	1.044	1.011-1.079*
1.045	1.021-1.069	1.056	1.032-1.080*	1.054	1.030-1.079*	1.041	1.018-1.064*	1.036	1.013-1.059*	1.042	1.019-1.065*	1.058	1.034-1.083*
.989	.884-1.107	.927	.832-1.032	.904	.807-1.012	1.021	.909-1.147	1.063	.938-1.205	1.004	.900-1.119	.982	.860-1.076

*p<.05,** p<.01



perceived their family functions as unhealthy. There is also consistent evidence about the fact that the impact of chronic trauma on individual family members and, in turn, on multiple family subsystems. Childhood physical abuse had a higher prevalence of the wish to be hurt, and experienced others as strict and stern (Kiser & Black, 2005; Drapeau & Perry, 2004).

Regression analyses were conducted to see if there is any causal relationship. Regression analyses also supported these findings. Subjects who reported physical abuse during their childhood had significantly experienced unhealthy problem solving, roles, affective responsiveness, and general functions. PA experiences in childhood may lead to many problems in family. Children have unsuccessful problem solving, negative affective involvement, difficulty in female gender role acquirements, and problems in fulfilling the functions of family. In the same way, children who had EAN experiences in childhood may have problems about ensuring the exchange of information, direct expression desires, realizing the behavior pattern to provide family necessities, and showing most convenient reaction in many situations.

Furthermore, the results of the study demonstrated that university students have difficulty in expressing their emotions to other family members and may also have difficulty to communicate clearly and directly with them. Moreover they can not receive the necessary interest and value from other family members. Living under traumatic circumstances slowly erodes family processes, specifically structure, relations, and coping skills. Family structure is particularly vulnerable to the effects of chronic trauma (Kiser & Black, 2005; Drapeau & Perry, 2004). As a result, it can be said that childhood traumas which are PA and EAN predict disruption in family functioning.

Several limitations of this study should also be noted. One of them is that the present study was unable to explore more detailed dimensions of abuse history such as type, perpetrator, duration, or age at onset of abuse. Another limitation is that the self-reported and retrospective nature of data, considering especially the nature of the issues such as childhood trauma experiences may have limited reliability.

These findings provide support for the view that familial problems are risk factors behind childhood traumas for the young individuals. The common factor of all traumatic experiences is about the fact that they can be prevented. Therefore, society must be trained about the risk factors of childhood traumas so that different segments of society such as parents, teachers and professional health workers will pay attention to traumatic experiences. Preventive interventions on childhood abuse and neglect may also increase quality of family functions.

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